STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155199	A. BUILDING 00 B. WING	04/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE PARK VILLAGE	776 N UNION ST WESTFIELD, IN 46074

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F0000	This visit was for a Recertification and State Licensure Survey. This visit included Investigation of Complaint IN00105665. Complaint IN00105665: Substantiated. Federal/state deficiencies related to the allegations are cited at F314. Survey dates: April 16, 17, 18, and 19, 2012. Facility number: 000106 Provider number: 155199 AIM number: 100266390 Survey team: Michelle Hosteter RN-TC Heather Lay, RN Janet Stanton, RN Melanie Strycker, RN Census bed type: SNF: 9 SNF/NF: 88 Total: 97 Census payor type: Medicare: 15 Medicaid: 53 Other 29 Total: 97	F0000	May 8 th 2012 Dear Kim Rhoades, Please find the attached Plan of Corrections for the Health Recertification and State Licensure survey in conjunction with complaint survey #IN00105665 performed on April 16,17,18, and 19, 2012. The provider respectfully requests that the 2567 plan of correction be considered the letter of credible allegation and requests a desk review, in lieu of a Post Survey revisit. Sincerely, Zach Krumwied, HFA Executive Director Maple Park Village The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Sample: 20 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed on April 26, 2012 by Bev Faulkner, R.N.			

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F0271 SS=B	483.20(a) ADMISSION PHYSICIAN ORDERS FOR IMMEDIATE CARE At the time each resident is admitted, the facility must have physician orders for the resident's immediate care. Based on interview and record review, the facility failed to obtain a physician order for 4 of 4 residents reviewed, who were admitted directly to and resided on the Dementia/Alzheimer's locked/secured unit, to be admitted to that unit; in a sample of 20 residents reviewed. [Residents #5, #13, #17 and #J] Findings include: In an interview on 4/18/12 at 10:53 A.M., the Executive Director indicated the facility's locked/secure Dementia/Alzheimer's unit was first opened in October 2011. The clinical records for 4 residents, currently residing on that unit, had the following information: 1. Resident #5: The clinical record was reviewed on 4/18/12 at 2:45 P.M. The resident was originally admitted by a transfer from another facility that did not have a secured/locked dementia unit, on 3/30/12. There was no physician order for the	F0271	483.20 (a) ADMISSION PHYSICIAN ORDERS FOR IMMEDIATE CARE In regards to residents #5, #J, 13 and #17, Physician orders were obtained for residents #5, #J, #13, and #17 to be admitted to a secured unit. All residents that reside on the memory care unit have the potential to be affected. Physician orders were obtained for all residents that reside on the memory care unit to be admitted to a secured unit. Physician orders to admit to a secured unit will be obtained for all residents that admit to the memory care unit at admission. All admissions to the memory care unit will be reviewed by the IDT team prior to admission to ensure that an admission order is obtained for a secured unit. To ensure compliance, the DNS/Designee is responsible for the completion of the memory care admission CQI tool weekly times 4 weeks, bi-monthly times 2 months, and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED, If threshold of 95% is not achieved an action plan will be developed to ensure compliance.	05/17/2012

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	resident to be admitted directly to the secured/locked unit. 2. Resident #J: The clinical record was reviewed on 4/17/12 at 8:40 A.M. The resident was admitted directly from his home to the secured/locked unit on 2/1/12. There was no physician order for the resident to be admitted to the secured/locked unit. 3. Resident #13: The clinical record was reviewed on 4/18/12 at 9:40 A.M. The resident was admitted directly from an acute care psychiatric unit on 12/8/11. There was no physician's order for the resident to be admitted to the secured/locked unit. 4. Resident #17: The clinical record was reviewed on 4/17/12 at 1:20 P.M. The resident was originally admitted by a transfer from an assisted living facility that did not have a secured/locked dementia unit, on 1/2/12. There was no physician order for the resident to be admitted to the secured/locked unit. In the interview on 4/18/12 at 10:53		Compliance Date: 05/17/2012	

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	A.M., the Executive Director indicated the facility had not obtained physician orders for admittance to the Dementia/Alzheimer's unit for any of the residents currently residing on that unit. He indicated they were not aware that a physician order for that unit was required. 3.1-30(a)			

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F0281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. Based on observation, interview and record review, the facility failed to ensure 2 Q.M.A.s [Qualified Medication Aide] did not perform care that was outside their scope of practice by applying a treatment cream to an open pressure sore area; for 1 of 6 residents reviewed who had pressure sore areas. [Resident #J, Q.M.A. #5 and #10] Findings include: In an interview during the initial orientation tour on 4/16/12 at 10:30 A.M., L.P.N. #3 indicated Resident #J had a Stage II open area on his coccyx area. She indicated the resident acquired the area since his admission because "he scoots a lot" [while sitting in his wheelchair]. The clinical record for Resident #J was reviewed on 4/17/12 at 8:40 A.M. Diagnoses included, but were not limited to, senile dementia--Alzheimer's type with behavior disturbance, non-insulin dependent diabetes, anxiety state, depressive disorder, hypertension, and anemia.	F0281	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS Regarding Resident J, His area is cleansed and the treatment was applied by qualified personnel. All residents have the potential to be affected. An inservice will be provided for QMA #5 and QMA #10 regarding their scope of practice by the DNS or designee by 05.17.12. A medication administration skills validation will be completed by the DNS or designee by 05.17.12 for QMA #5 and QMA #10. An inservice will be provided to licensed nurses and QMAs regarding their scope of practice and medication administration procedure by the DNS or designee by 05.17.12. Licensed nursing staff and QMA staff will complete a medication administration skills validation by 05.17.12. To ensure compliance, the DNS/Designee is responsible for the completion of the medication administration /skills validation CQI tool weekly times 4 weeks, bi-monthly times 2 months, and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED,	05/17/2012

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	An electronic progress note, dated 3/21/12 at 10:29 P.M., indicated "Noted (2 centimeter by 1 cm.) reddened open area on coccyx. Notified M.D. for treatment." On 3/22/12, the attending physician ordered "Calmoseptine cream to open area coccyx every shift." An Interdisciplinary Team progress note, dated 4/11/12, indicated "... Coccyx now Stage III." A Wound Care clinic progress note, dated 4/13/12, indicated "Sacrum, 1.5 by 0.9 by 0.1 centimeters; unstageable pressure, suspected deep tissue injury; 80% granulation, 20% fibrin/slough...." On 4/17/12 at 2:45 P.M., Q.M.A. #5 was observed providing incontinence care to the resident following an incontinent bowel movement. After cleaning the resident's rectal, buttock, and coccyx areas, the Q.M.A. said "I need to put more cream on this [indicating the nickel-size open area on the upper coccyx area]." She reached into the bedside stand drawer, removed the tube of Calmoseptine cream, squeezed a small amount onto her gloved index finger, and applied it to the open area.		If threshold of 95% is not achieved an action plan will be developed to ensure compliance. Compliance date: 05/17/2012	

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On 4/19/12 at 8:45 A.M., the Director of Nursing provided a copy of the "Qualified Medication Aide Position Description," with a revision date of 7/13/05. The "Summary of Position Functions" indicated "The Qualified Medication Aide sets up, administers, and records certain prescribed medications for residents in the facility under the supervision of a licensed nurse and as allowed by State regulatory agencies."

The "Essential Position Functions" included, but was not limited to, "... Prepares and administers topical medications to intact skin...."

The April, 2012 M.A.R. [Medication Administration Record] listed the Calmoseptine cream order. On 4/19/12 at 1:30 P.M., the Director of Nursing identified that the application of the cream on 4/1 and 4/10/12 for the 11-7 shift was initialed by Q.M.A. #10. In an interview, she indicated she had not been aware a Q.M.A. was applying the cream.

The Indiana State Department of Health "Qualified Medication Aide Basic Curriculum" manual, dated October, 2003, includes, but is not limited to, the following information:

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	"412 IAC 2-1-9 Scope of Practice... (12) Apply topical medication to minor skin conditions such as dermatitis, scabies, pediculosis, fungal-infection, psoriasis, eczema, first degree burn, or Stage I decubitus ulcer...." "Curriculum--Lesson 1: Role and Responsibilities of the Qualified Medication Aide... III. Tasks that the QMA is PROHIBITED from Performing... H. Administer a treatment that involves an advanced skin condition, including Stage II, III, and IV decubitus ulcers...." 3.1-35(g)(1)			

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F0314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Based on observation, interview and record review, the facility failed to ensure appropriate interventions were in place to prevent and help heal an open Stage II pressure ulcer, for 1 of 6 residents reviewed for pressure ulcer potential or issues, in a sample of 20 residents. [Resident #J] Findings include: In an interview during the initial orientation tour on 4/16/12 at 10:30 A.M., L.P.N. #3 indicated Resident #J had a Stage II open area of the coccyx, which he acquired after admission because he "scoots a lot" [in his wheelchair]. The clinical record for Resident #J was reviewed on 4/17/12 at 8:40 A.M. Diagnoses included, but were not limited to, senile dementia--Alzheimer's type with behavioral disturbances, non-insulin	F0314	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Regarding Resident #J, a root cause analysis was performed to determine the cause of the pressure ulcer. An occupational therapy screen was performed and as a result, the wheelchair seating surface was changed to provide optimal pressure reduction and promote wound healing. A care plan approach was initiated to observe the resident's posture for scooting, slouching and sliding in the wheelchair and to make corrective posture changes in order to reduce pressure points. All residents with pressure ulcers or who have the potential for development of pressure ulcers have the potential to be affected. A skin evaluation will be conducted on all residents in the facility to identify any resident with a pressure ulcer. Any resident with a pressure-related injury will have a root cause analysis	05/17/2012

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	dependent diabetes, anemia, anxiety state, and depressive disorder. A quarterly M.D.S. [Minimum Data Set] assessment, dated 3/28/12, indicated the resident had a BIMS [Brief Interview for Mental Status] score of "03" [0-7=severe cognitive impairment]; required extensive physical assistance of 1-2 staff for all daily care; and was always incontinent of both bowel and bladder. The assessment also indicated the resident had an unhealed, unstageable deep tissue injury open area. An electronic progress note, dated 3/21/12 at 10:29 P.M., indicated "Noted (2 centimeter by 1 cm.) reddened open area coccyx. Notified M.D. for treatment." On 3/22/12, the physician ordered "Calmoseptine to open area on coccyx every shift." An electronic IDT [Interdisciplinary Team] progress note, dated 3/23/12, indicated "Initial Wound--[Resident's name] had an unstageable wound on coccyx. Appears deep tissue injury. Dark in center with red surrounding area. Up in wheelchair for most of meals. Cushion in wheelchair. Re-distribution mattress on bed. Measures 1.5 cm by 0.5 cm."		and a care plan implemented with individualized prevention and healing measures. All residents will receive a pressure risk assessment on admission, quarterly, annually and with significant change. A care plan will be initiated and preventative interventions will be put in place for all residents at risk for pressure ulcer. All licensed staff will be provided an inservice by the DNS or designee by 05.17.12 on skin management with identification of pressure ulcer risk factors and preventive interventions. A weekly skin assessment will be performed on all residents to identify any abnormal findings. IDT will conduct a root cause analysis for any resident that develops a pressure-related injury. Adjustments to the interventions will be implemented with focus on individualized healing approaches. Therapy will be notified of any new pressure wound to evaluate positioning and seating. An IDT wound team will evaluate weekly to assess the wound and determine appropriateness of interventions and progress toward healing. The affected resident will be audited 5 times per week for 4 weeks to identify correct wheelchair posture and position. The affected resident will be audited weekly to assess the wound appearance and healing until the wound is healed. To ensure compliance, the	

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	There was no information related to the means by which the resident acquired a deep tissue injury of the coccyx. Electronic progress notes from admission on 2/1/12 had no documentation related to the resident "scooting" or slouching or sliding in his wheelchair. An initial Wound Care clinic note, dated 3/23/12, indicated the resident had a 4.5 by 3.5 by 0 cm. pressure etiology, unstageable deep tissue injury, with 35% granulation, 35% epithelialization, and small amount of sero-sanguious drainage. The most current visit from the Wound Care clinic on 4/13/12 indicated the area was a pressure etiology, unstageable deep tissue injury 1.5 by 0.9 by 0.1 cm, with 80% granulation, 20% fibrin/slough, and small amount of sero-sanguious drainage. There was no information related to the cause of the deep tissue injury, or plans to assist in healing other than "continue treatment [with Calmoseptine]," and "turn frequently." In an interview during the daily conference on 4/17/12 at 3:30 P.M., the Director of Nursing indicated the Therapy Department had seen and evaluated the resident for posture and positioning in his wheelchair due to his Parkinson's disease.		DNS/Designee is responsible for the completion of the skin management CQI tool weekly times 4 weeks, bi-monthly times 2 months, and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED, If threshold of 95% is not achieved an action plan will be developed to ensure compliance. Compliance date: 05/17/2012	

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	On 4/18/12, copies of the Occupational Therapy Treatment Notes, from 2/2 through 3/13/12, were provided for review. The Therapy plan was to provide ADL [Activity of Daily Living] and transfer training, strengthening/coordination exercises, and wheelchair positioning and management. A note, dated 2/7/12, indicated "Increased rigidity and tremors observed this date, bilateral hands clenched, poor sitting posture. Reposition hips in wheelchair with fair results...." A note on 2/25/12 indicated "... Good sitting posture in wheelchair while sitting at the table noted...." A note on 3/12/12 indicated "Good wheelchair positioning for self feeding...." The resident was discharged from therapy on 3/14/12 "due to plateau in progress...." There was no documentation indicating the resident had been "scooting," slouching or sliding in his wheelchair, and no recommendations addressing this issue. On 4/17/12 at 10:10 A.M., the resident was observed sitting up in his wheelchair in the Dining/Activity area. There was a pressure-relieving cushion under him, in the seat of the wheelchair. The resident was observed to use his upper torso to jerk/propel the wheelchair a few inches at a time. Although the resident was not slouching or sliding down in the			

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	wheelchair, he had moved his bottom forward in the seat so that he was sitting near the front edge of the wheelchair. Staff approached and assisted him to move his bottom to the back of the wheelchair seat and against the chair back. On 4/17/12 at 2:45 P.M., Q.M.A. #5 was observed providing incontinence care to the resident following an incontinent bowel movement. After cleaning the resident's rectal, buttock, and coccyx areas, the Q.M.A. said "I need to put more cream on this [indicating the nickel-size open area on the upper coccyx area]." On 4/18/12 from 1:05 to 3:30 P.M., the resident was observed laying in bed on his back. A Care Plan entry, dated 3/22/12, addressed a problem of "Resident has impaired skin integrity: deep tissue injury. Location: sacrum." The "Approaches" [interventions] were listed as: "Assess for pain, treat as ordered. Notify M.D. of unrelieved/worsening pain; Assess wound weekly documenting measurements and description; Encourage resident to eat at least 75% of meals; Incontinent care as needed; Labs as ordered; Notify M.D. of worsening or no change in wound or for signs of infection;			

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	Observe for signs of infection [signs listed]; Pressure redistribution mattress on bed; Pressure relieving cushion in chair; Treatment as ordered; Turn and reposition every 2 hours." Care Plan interventions addressing the resident's posture, scooting/slouching/sliding in wheelchair were not found. This Federal tag relates to Complaint IN00105665. 3.1-40(a)(2)			

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MAPLE PARK VILLAGE	776 N UNION ST WESTFIELD, IN 46074

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F0329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.			
	A. Based on interview and record review, the facility failed to ensure a PRN [pro re nata--"as needed"] anti-anxiety medication was not given before other alternative non-medication interventions were tried; for 1 of 11 residents reviewed who were receiving psychotropic medications, in a sample of 20 residents. [Resident #J] B. Based on interview and record review, the facility failed to ensure blood pressure monitoring was performed prior to	F0329	483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Residents #J and #60 were affected. Regarding resident J, the prn medication will not be administered until alternative non-medication interventions are tried and documented in the medical record. Regarding Resident 60, Physician was notified. Per observation no adverse effects were noted from the administration of the hydralazine. The hydralazine will be administered per physician's order. All residents have the potential to be	05/17/2012

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	administering a blood pressure medication that had a physician order to "Hold" for certain parameters; for 1 of 1 residents reviewed who had such orders; in a sample of 20 residents. [Resident #64] Findings include: A.1. In an interview during the initial orientation tour on 4/16/12 at 10:30 A.M., L.P.N. #3 indicated Resident #J had delusional behaviors and "acted out." She indicated he was receiving psychotropic medications. The clinical record for Resident #J was reviewed on 4/17/12 at 8:40 A.M. Diagnoses included, but were not limited to, senile dementia--Alzheimer's type with behavior disturbances, anxiety state, and depressive disorder. The April, 2012 physician order recap [recapitulation] sheet listed an order, originally dated 2/1/12, for Alprazolam [Xanax--an anti-anxiety medication] 0.5 mg. [milligrams] one three times a day P.R.N. The "Controlled Substance Record" for the P.R.N. Alprazolam indicated the resident received 28 doses in February; 33 doses in March; and 18 doses in April		affected. LPN #1 and LPN #3 will receive an inservice by the DNS or designee regarding medication administration procedure/non-medication interventions and complete a medication administration skills validation by 05.17.12. An inservice regarding medication administration/non-medication interventions procedure will be provided by SSD or designee to all licensed nursing staff and QMAs by 05/17/2012. Skills validations regarding medication administrations will be completed by all licensed nursing staff and QMAs regarding following physicians orders and non-medication interventions. Licensed staff will contact the DNS or designee prior to the administration of a prn psychotropic to ensure non-medication intervention(s) were attempted. To ensure compliance, the DNS/Designee is responsible for the completion of unnecessary medications CQI tool weekly times 4 weeks, bi-monthly times 2 months, and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED, If threshold of 95% is not achieved an action plan will be developed to ensure compliance. Compliance date: 05/17/2012	

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	through 4/15/12. The reverse side of the M.A.R. [Medication Administration Record] form has columns for documenting the date and time a PRN medication is given, the name of the medication and dosage, the reason for administering, the results or response, and the nurse's signature and title. The February, March, and April 2012 M.A.R.s for Resident #J indicated the P.R.N. Alprazolam was given for "complaint of anxiety," and that it was "helpful." There was no documentation on the M.A.R. related to other alternative non-medication interventions tried before administering the medication. Electronic progress notes from 2/1/12-4/17/12 were reviewed. A progress note, dated 4/13/12 at 7:49 P.M., indicated a dose of Alprazolam was given at 7:15 P.M.--"Tried to talk with resident, didn't work." A progress note, dated 4/14/12 at 1:18 P.M., indicated "Trying to stand up, pushing tables. Redirected several times--received P.R.N. Xanax at 12:00 noon." A progress note on 4/15/12 at 9:00 P.M., indicated "Given P.R.N. Xanax at 7:55 P.M. due to increased anxiety. Pushing tables back and forth with feet and			

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	wheelchair. Before P.R.N. Xanax, removed from area, given 1:1, offered diversional activities--none effective." There were no other entries related to alternative non-medication interventions tried before the Alprazolam was given. In an interview during the daily conference on 4/17/12 at 3:30 P.M., the Executive Director and Director of Nursing Services indicated a behavior flow sheet was located in the M.A.R., and was used to track behaviors for each shift. In an interview on 4/18/12 at 10:53 A.M., the Executive Director indicated the behavior flow sheets did not have information about alternative non-medication interventions tried before the Alprazolam was administered. He indicated they did not have any other documentation related to alternative non-medication interventions that may have been tried prior to the administration of the Alprazolam. B.1.. On 4/19/12 at 7:30 A.M., medication pass was observed with Licensed Practical Nurse [LPN] #1. On 4/19/12 at 7:30 A.M., LPN #1 was observed passing medications to Resident #64.			

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	At that time, Resident #64 was administered Hydralazine 100 milligrams by mouth. On 4/19/12 at 7:45 A.M., Resident #64's physician's orders were reviewed. A "Physician's Orders" dated 4/12/12, no time, included, but was not limited to, "Hydralazine 100 milligrams three times daily... hold for systolic blood pressure less than 120..." In an interview on 4/18/12 at 7:50 A.M., LPN #1 indicated Resident #64 was not on any medications that required her to check a blood pressure so Resident #64's blood pressure was not checked. 3.1-48(a)(3) 3.1-48(a)(4)			

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F0333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. Based on observation, record review and interview, the facility failed to ensure insulin was given in accordance with manufacturer's guidelines in order to prevent potential significant medication error for 2 of 2 residents observed receiving insulin from the 8 residents observed during medication pass. [Residents #60 and #36] Finding include: 1. On 4/19/12 at 7:30 A.M., medication pass was observed with Licensed Practical Nurse [LPN] #1. At 8:30 A.M., LPN #1 was observed administering, Resident #60, 16 units of Novolog insulin subcutaneous to the left outer arm. At that time, in an interview, LPN #1 indicated Resident #60's insulin sliding scale orders were confusing and she was to give Resident #60's insulin 1 hour before breakfast but she didn't understand why it was ordered that way. LPN #1 indicated Resident 60's blood sugar at 7:00 A.M. was 193.	F0333	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS Residents #60 and #36 were affected. In regards to resident #60, the physician was contacted and the resident was observed with no adverse affect noted. Resident #60's insulin will be administered per physician's order. Regarding resident #36, the physician was contacted and the resident was observed with no adverse affects noted. Resident #36's insulin will be administered per physician's order. All residents receiving insulin have the potential to be affected. LPN #1 and LPN #2 will receive an inservice regarding the administration of insulin by the DNS or designee by 05.17.12. LPN #1 and LPN #2 will complete a skills validation regarding medication administration by 05.17.12. All licensed nursing staff will receive an inservice by the DNS or designee regarding the administration of insulin and complete a skills validation regarding medication administration by 05.17.12. Residents that require medication administration with meal will be provided with an adequate snack/meal at minimum during med pass times to maintain compliance with physician orders and	05/17/2012

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	In an interview at 8:35 A.M., Resident #60 indicated she ate breakfast in her room at 8:00 A.M. Therefore, Resident #60's insulin dose should have been administered at 7:00 A.M. Resident #60's insulin was 1 1/2 hours late. On 4/19/12 at 8:45 A.M., Resident #60's physician's orders were reviewed. A "Physician's Orders" dated 4/12/12, no time, included, but was not limited to, "Novolog Insulin Correction Scale... 16 units if blood sugar 121 to 200... 1 hour before meals..." 2. On 4/18/12, from 11:00 A.M. to 11:10 A.M., medication pass was observed. LPN #2 was observed to prepare Resident #36's insulin medication. In an interview at that time, LPN #2 indicated the resident eats lunch at 11:30 A.M. The insulin was observed given to the resident at 11:07 A.M. The resident was observed to receive his meal tray at 11:52 A.M., and the resident was observed to begin eating. Resident #36's record was reviewed on 4/18/11 at 11:12 A.M. The resident had a diagnosis of insulin dependent diabetes.		medication guidelines. To ensure compliance, the DNS/Designee is responsible for the completion of the medication administration /skills validation CQI tool weekly times 4 weeks, bi-monthly times 2 months, and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED, If threshold of 95% is not achieved an action plan will be developed to ensure compliance. Compliance Date: 05/17/2012	

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	The physician's order, dated 2/28/12, indicated "Accuchecks [finger stick blood test for blood sugar] before meals and at bedtime. Novolog 100 unit/ml vial. Inject sub-q [subcutaneously] per sliding scale." "Mosby's Nursing Drug Reference," 2010 edition, obtained from facility's medical records department indicated Novolog was a short acting insulin. The administration of Novolog was to be "just prior to beginning of meal." The manufacturer's guidelines provided by the Director of Nursing on 4/18/12 at 12:50 P.M. indicated the following: "Take Novolog exactly as prescribed. You should eat a meal within 5 to 10 minutes after using Novolog to avoid low blood sugar." "Do not inject Novolog if you do not plan to eat right after your injection or bolus pump infusion." 3.1-48(c)(2)			

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F0371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview and record review, the facility failed to ensure labeling and dating of food items in 1 of 1 refrigerators on the Cottage unit and to ensure dishes are stacked in manner to prevent bacteria growth for 1 of 1 kitchens. The undated and unlabeled food had the potential to affect 20 of 20 residents residing in the Cottage unit. The prevention of bacteria growth on dishes had the potential to affect 95 out of 97 residents receiving food from 1 of 1 kitchen. Findings include: 1. The environmental tour began on 4/18/12 at 1:00 P.M., with the Administrator, Maintenance Director and Housekeeping and Laundry Supervisor. At 2:05 P.M. during the tour of the Cottage (a unit for residents with Alzheimer's disease and dementia) the refrigerator was found to have un undated open 64 ounce container of V8 juice and butter container with no date it was	F0371	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE –SANITARY No specific residents were listed as being affected. All residents residing on the cottage unit have the potential to be affected by the unlabeled and undated food items. All items that were unlabeled or undated were discarded. All residents have the potential to be affected by the manner that the dishes were stacked with moisture. The dishes identified with moisture present were cleaned, sanitized, and air-dried prior to stacking. Staff members will be inserviced on the storage and labeling of food items that are refrigerated by the dietary manager or designee by 05.17.12. Dietary staff will be inserviced by the dietary manager or designee on the procedure for sanitizing, cleaning, and air-drying of dishes by 05.17.12. The dietary manager or designee will inspect all food in the memory care refrigerator daily and discard any item not labeled or dated appropriately. New dietary storage equipment has been purchased and will be used to allow	05/17/2012

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	opened. In an interview with the Administrator at 2: 07 P.M., he indicated the items in the refrigerator should be labeled and dated. A request was made regarding a policy for dating of food items and the policy provided on 4/18/12 at 4:25 P.M., was titled "Dietary/Food Services" and had a review date of 2/12. The Administrator indicated this is the only policy they have for this concern. The policy did not indicate any information regarding dating and labeling of the food items. "Retail Food Establishment Sanitation Requirements Title 410 IAC 724" effective 11/13/04 indicates the following in regards to date marking and disposition: "...refrigerated, ready-to-eat, potentially hazardous food prepared and packaged by a food processing plant shall be clearly marked, at the time the original container is opened...(2) the day or date marked by the retail food establishment may not exceed a manufacturer determined the us-by-date based on food safety..." 2. During the initial observation of the kitchen on 4/16/12 at 10:05 A.M., a three-tiered cart at the end of the serving line contained 3 plate covers with		proper air-drying of dishes. To ensure compliance, the dietary manager/designee is responsible for the completion of the refrigerator audit CQI tool weekly times 4 weeks, bi-monthly times 2 months, and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED, If threshold of 95% is not achieved an action plan will be developed to ensure compliance. Compliance date: 05/17/2012	

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	moisture on the inside of the lid. These lids were stacked one on top of the other with the inside surfaces down. During observation in the kitchen on 4/19/11 at 11:05 A.M., adjacent to the dishwasher area on a storage rack, trays were observed with several stacks of five small bowls, eight stacks of five medium bowls. Another shelf contained four trays with drink glasses stored upside down. Also observed on the serving line were stacks of plate lids. These items were observed to have moisture inside them. During an interview at this same time, the Dietary Services Manager indicated these items were clean dishes and she thought they were dry. "Retail Food Establishment Sanitation Requirements Title 410 IAC 724" effective 11/13/04 indicates the following: "SEC 304(a) After cleaning and sanitizing, equipment and utensils: (1) shall be air-dried or used after adequate draining as specified in 21 CFR 178.1010(a), before contact with food...." 3.1-21(i)(2) 3.1-21(i)(3)			

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F0441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation, interview and record review, the facility failed to ensure	F0441	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	05/17/2012

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	2 staff performed correct techniques for disposable glove use and handwashing during and after providing 1 resident with incontinence care, after that resident had an incontinent bowel movement. This deficiency impacted 1 of 1 resident reviewed, in a sample of 20 residents. [Resident #J, Q.M.A. #5, C.N.A. #4] Findings include: In an interview during the initial orientation tour on 4/16/12 at 10:30 A.M., L.P.N. #3 indicated Resident #J had a Stage II open area of the coccyx. The clinical record for Resident #J was reviewed on 4/17/12 at 8:40 A.M. Diagnoses included, but were not limited to, senile dementia--Alzheimer's type with behavioral disturbances, non-insulin dependent diabetes, anemia, anxiety state, and depressive disorder. A quarterly M.D.S. [Minimum Data Set] assessment, dated 3/28/12, indicated the resident had a BIMS [Brief Interview for Mental Status] score of "03" [0-7=severe cognitive impairment]; required extensive physical assistance of 1-2 staff for all daily care; and was always incontinent of both bowel and bladder. The assessment also indicated the resident had an unhealed, unstageable deep tissue injury		In regards to resident #J, his area was cleansed and his treatment is being applied appropriately. His room and furniture were cleaned and sanitized. All other residents have the potential to be affected. QMA #5 and CNA #4 will be inserviced by the DNS or designee on handwashing and the use of gloves by 05.17.12. QMA #5 and CNA #4 will complete a skills validation of glove use and handwashing by05.17.12. An inservice regarding handwashing and the use of gloves will be provided by the DNS or designee to facility staff by 05.17.12. Skills validations will be completed by facility staff in regards to handwashing and glove use by 05.17.12. To ensure compliance, the DNS/Designee is responsible for the completion of the infection control CQI tool weekly times 4 weeks, bi-monthly times 2 months, and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED, If threshold of 95% is not achieved an action plan will be developed to ensure compliance. Compliance date: 05/17/2012	

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	155199	A. BUILDING 00 B. WING	04/19/2012

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	open area. On 4/17/12 at 2:45 P.M., Q.M.A. #5 and C.N.A. #4 were observed while providing care after the resident had experienced an incontinent bowel movement. After entering the room and positioning the resident in bed on his left side, both staff put on disposable gloves. C.N.A. #4 assisted the resident in staying on his left side, while Q.M.A. #5 cleaned the resident's bottom. During the process and after putting on the gloves, the Q.M.A. reached into the bedside stand drawer to remove some disposable wipes from a package in the drawer. She used the wipes to clean some of the B.M. [bowel movement] from the resident's rectal, buttock and lower coccyx area. She disposed of these into a plastic bag held by C.N.A. #4, then reached into the bedside stand drawer to get more wipes. She did this several times, without changing her gloves, until the resident's rectal area, buttocks, and coccyx area were cleaned. After cleaning the resident, the Q.M.A. reached back into the bedside drawer and removed a tube of Calmoseptine cream. She said "I need to put more of this on" [indicating the nickel-size open area on the coccyx.] Without having changed her			

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	disposable gloves, the Q.M.A. applied some of the cream to the area with her gloved finger. When the staff had completed the care, they put a clean brief on the resident, positioned him in bed, and bagged all soiled linen and disposable care items in two separate bags. Before tying the tops, they each removed their disposable gloves and placed into one of the bags. The Q.M.A. picked up the bag containing the soiled brief and wipes, and went to the room door. As she used the heel of her hand to open the lever-type door handle, she said "They won't allow us to use the resident's bathroom to wash our hands." The C.N.A., carrying the other bag, went down the hall to the shower room, where the soiled linen/trash barrels were located, and used the key hanging by the door to unlock the door, and went in. She was followed by the Q.M.A. through the door. During the daily conference on 4/18/12 at 4:00 P.M., the Executive Director and the Director of Nursing Services were given the opportunity to provided any policy/procedure related to use of gloves and handwashing techniques to be used when providing incontinence care. In an interview at that time, both indicated they were not aware of any prohibition for			

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	staff to use a resident's bathroom to perform handwashing following care. On 4/19/12 at 8:45 A.M., the Executive Director provided an undated sheet of paper titled "Standard Precaution Usage Guidelines." The paper included, but was not limited to, the following: "Hand Hygiene: Hand washing with soap & water required. Guideline: Hands visibly soiled, ... before & after assisting a resident with toileting, ... after touching blood, body fluids, secretions, excretions, or contaminated items...." Personal Protective Equipment--Gloves. Guideline: Used for touching or possible contact with blood, body fluids, secretions, excretions, contaminated items; for touching or possible contact with mucous membranes or non-intact skin.... Linens & Laundry. Guidelines: Gloves should be worn when handling soiled linens or laundry. Proper bagging and closing to prevent the transfer/spread of possible organisms. After removal of gloves, hand washing with soap & water should be done...." 3.1-18(b)(1) 3.1-18(l)			

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F0514 SS=E	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. Based on interview and record review, the facility failed to document the specific criteria used, a summary of information collected, and the decision-making process, to demonstrate that residents were appropriately admitted to the facility Dementia/Alzheimer's secured/locked unit. This deficiency impacted 4 of 4 residents reviewed who were admitted directly to that unit; in a sample of 20 residents reviewed. [Residents #5, #13, #17, and #J] Findings include: In an interview on 4/18/12 at 10:53 A.M., the Executive Director indicated the facility's locked/secure Dementia/Alzheimer's unit was first opened in October 2011.	F0514	483.75(l)(1) RES RECORDS-COMPLETE/ACCESSIBLE In regards to residents #5, #13, #17, and #J, a comprehensive assessment was performed prior to admission to determine if the resident was appropriate to live on a secured/locked unit. A late entry was documented in the clinical record regarding this assessment by the IDT team. All other residents that reside on the memory care unit have the potential to be affected. Comprehensive assessments were performed prior to admission to determine if the residents were appropriate to live on a secured/locked unit. Late entries were documented in the clinical records regarding these assessments by the IDT team. The IDT team received an inservice on 4.19.12 regarding the process for assessing a resident's	05/17/2012

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	The clinical records for 4 residents, currently residing on that unit, had the following information: 1. Resident #5: The clinical record was reviewed on 4/18/12 at 2:45 P.M. The resident was originally admitted by a transfer on 3/30/12 from another facility that did not have a secured/locked dementia unit. Documentation of a comprehensive assessment, which included information about the resident gathered prior to the admission, and the process used to determine if she was appropriate to live on a secured/locked unit, was not found. 2. Resident #J: The clinical record was reviewed on 4/17/12 at 8:40 A.M. The resident was admitted directly from his home to the secured/locked unit on 2/1/12. Documentation of a comprehensive assessment, which included information about the resident gathered prior to the admission, and the process used to determine if he was appropriate to live on a secured/locked unit, was not found. 3. Resident #13: The clinical record was reviewed on 4/18/12 at 9:40 A.M. The resident was admitted directly from an		appropriateness for the memory care unit and the method for documenting such assessments. Potential admissions to the memory care unit will receive a comprehensive assessment regarding the appropriateness for residing on the memory care unit based on meeting memory care unit criteria. An IDT note documenting this assessment will be documented in the clinical record. To ensure compliance, the ED/Designee is responsible for the completion of the memory care admission CQI tool weekly times 4 weeks, bi-monthly times 2 months, and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED, If threshold of 95% is not achieved an action plan will be developed to ensure compliance. Compliance date: 05/17/2012	

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	acute care hospital psychiatric unit on 12/8/11. Documentation of a comprehensive assessment, which included information about the resident gathered prior to the admission, and the process used to determine if he was appropriate to live on a secured/locked unit, was not found. 4. Resident #17: The clinical record was reviewed on 4/17/12 at 1:20 P.M. The resident was originally admitted on 1/2/12 by a transfer from an assisted living facility that did not have a secured/locked dementia unit. Documentation of a comprehensive assessment, which included information about the resident gathered prior to the admission, and the process used to determine if she was appropriate to live on a secured/locked unit, was not found. On 4/18/12 at 8:30 A.M., the Executive Director provided a copy of the required "Alzheimer's/Dementia Special Care Unit" [State Form 48896] form, dated 10/18/11. The form indicated the facility had a "formal written process for: physician's evaluation/diagnosis, staff evaluation, psychiatric evaluation/diagnosis, family conference, appeal procedure, other...."			

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	On 4/18/12 at 10:20 A.M., the Executive Director provided a copy of the "Auguste's Cottage [the name of the facility's Dementia/Alzheimer's unit] Admission, Transfer and Continued Stay Criteria" letter, included in the admission information packet. The letter included, but was not limited to, the following information: "The intent of the Auguste's cottage program is to provide a home-like environment, to those challenged with various dementia diagnoses, that maximizes dignity, productivity and quality of life. Admission to the program is not based solely upon diagnosis or disease state, but is based on a variety of criteria as dictated by the state of Indiana and American Senior Communities. The decision to accept an individual into the Auguste's Cottage program is made at the facility level and is based upon the best information gathered by an interdisciplinary team following the initial admission assessment...." The specific criteria used to determine appropriate admission to the unit was not specified. In an interview on 4/18/12 at 10:53 A.M.,			

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	the Executive Director indicated the IDT [Interdisciplinary Team], attending physician, and family had discussions and gathered information, but those meetings and information were not documented. He indicated there were no written assessments that summarized all of the gathered pre- and post- admission information, and which demonstrated how the facility reached a decision to place one particular resident in the locked/secured unit as opposed to another who would not be placed in the unit. Specific criteria [such as wandering, exit-seeking, getting lost in the community, needing structured activities] to assist in making a decision to place a new resident in the locked/secured unit was not actually written down and available to use for determining placement. 3.1-29(b)(3) 3.1-50(a)(1) 3.1-50(a)(2)			